NON-PUBLIC?: N

ACCESSION #: 9010260121

LICENSEE EVENT REPORT (LER)

FACILITY NAME: South Texas, Unit 2 PAGE: 1 OF 3

DOCKET NUMBER: 05000499

TITLE: A Reactor Trip Caused by Manipulation of the Incorrect Reactor

Trip Breaker Test Pushbutton

EVENT DATE: 09/17/90 LER #: 90-013-00 REPORT DATE: 10/17/90

OTHER FACILITIES INVOLVED: DOCKET NO: 05000

OPERATING MODE: 1 POWER LEVEL: 100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR

SECTION: 50.73(a)(2)(iv)

LICENSEE CONTACT FOR THIS LER:

NAME: C. A. Ayala - Supervising Licensing Engineer

TELEPHONE: (512) 972-8628

COMPONENT FAILURE DESCRIPTION:

CAUSE: SYSTEM: COMPONENT: MANUFACTURER:

REPORTABLE NPRDS:

SUPPLEMENTAL REPORT EXPECTED: NO

ABSTRACT:

On September 17, 1990, Unit 2 was at 100% power. At 0330 hours, a reactor trip occurred during performance of the Train S Reactor Trip Breaker Trip Actuating Device Operational Test. A main feedwater isolation occurred on low Reactor Coolant System average temperature and the Auxiliary Feedwater System actuated on low steam generator level. Control room personnel responded in accordance with procedures and stabilized the plant. All systems responded as expected. The cause of the event was failure of a non-licensed operator to self verify that he was in position to open the correct reactor trip breaker panel prior to manipulation of the auto shunt trip test pushbutton. The non-licensed operator was counseled and received disciplinary action, in addition a training module emphasizing the importance of attention to detail and self-verification was developed and presented to employees engaged in

operations and maintenance of the plant.

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END OF ABSTRACT

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DESCRIPTION OF EVENT:

At 0330 hours on September 17, 1990, with Unit 2 in Mode 1 at 100% power, a reactor trip occurred during the performance of the Train S Reactor Trip Breaker Trip Actuating Device Operational Test (TADOT). A main feedwater isolation occurred on low Reactor Coolant System (RCS) average temperature and the Auxiliary Feedwater System actuated on a low-low steam generator level signal. No other ESF actuations occurred during this event. All systems responded as expected. Control room personnel responded in accordance with procedures and stabilized the plant at 0347 hours. The NRC was notified at 0400 hours.

The Solid State Protection System (SSPS) consists of logic trains R and S. At approximately 0240 hours on September 17, 1990, the Train S Reactor Trip Breaker TADOT was in progress. At approximately 0300 hours, a non-licensed operator was dispatched to the Train S reactor trip breaker to assist in performance of the Reactor Trip Breaker TADOT. The test proceeded under the direction of the Unit Supervisor who directed the non-licensed operator to depress the auto shunt trip test pushbutton in the Train S cabinet and he did so correctly. During a brief delay in the conduct of the test, the non-licensed operator opened the reactor trip breaker panel doors for Train R in addition to the panel doors for Train S which were already open to explain the operation of the breakers to a trainee. The panel doors for both Trains were closed after completion of the discussion. When conduct of the test resumed, the Unit Supervisor directed the non-licensed operator to depress the Train S auto shunt trip test pushbutton momentarily. The non-licensed operator repeated the instructions back to the Unit Supervisor who confirmed the instructions. At approximately 0330 hours the non-licensed operator incorrectly opened the Train R reactor trip breaker panel door and depressed the Train R auto shunt trip test pushbutton. This resulted in a reactor trip since the Train R reactor trip breaker had not been bypassed.

CAUSE OF EVENT:

The cause of the event was failure of the non-licensed operator to self verify that he was in position to open the correct reactor trip breaker panel prior to actual manipulation of the auto shunt trip test pushbutton.

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ANALYSIS OF EVENT:

Unplanned reactor protection system actuation is reportable pursuant to 10CFR50.73(a)(2)(iv). The reactor tripped as required and plant equipment operated as expected. There were no adverse radiological or safety consequences as a result of this event.

CORRECTIVE ACTION:

- 1. The non-licensed operator was counseled in regard to attention to detail and self verification. In addition, the non-licensed operator received disciplinary action.
- 2. A training module emphasizing the importance of attention to detail and self verification was developed and training has been conducted for employees engaged in maintenance and operation of the plant. Training will be completed site wide by December 15, 1990.

ADDITIONAL INFORMATION:

The reactor trip breakers at both STPEGS units are Westinghouse Type DS-416 low voltage circuit breakers.

LER 87-024, 88-045 and 88-059 identified similar events where an ESF actuation or reactor trip were attributed to an individual inadvertently operating an incorrect switch or button.

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The Light company South Texas Project Electric Generating Station P.O.Box 289 Wadsworth, Texas 77483

Houston Lighting & Power

October 17, 1990

ST-HL-AE-3588 File No.: G26 10CFR50.73

U. S. Nuclear Regulatory Commission Attention: Document Control Desk Washington, DC 20555

South Texas Project Electric Generating Station Unit 2 Docket No. STN 50-499 Licensee Event Report 90-013 Regarding A Reactor Trip Caused by Manipulation of the Incorrect Reactor Trip Breaker Test Pushbutton

Pursuant to 10CFR50.73, Houston Lighting & Power (HL&P) Company submits the attached Licensee Event Report (LER 90-013) regarding a reactor trip caused by manipulation of the opposite train reactor trip breaker test pushbutton during surveillance testing. This event had no adverse impact on the health and safety of the public.

If you should have any questions on this matter, please contact Mr. C. A. Ayala at (512) 972-8628 or myself at (512) 972-8530. Manager Nuclear Licensing RAD/sgs Attachment: LER 90-013 (South Texas, Unit 2)

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Houston Lighting & Power Company File No.:G26 South Texas Project Electric Generating Station Page 2

cc:

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Revised 10/08/90

L4/NRC

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